



King's Research Portal

DOI:

[10.1016/j.maturitas.2017.10.007](https://doi.org/10.1016/j.maturitas.2017.10.007)

Document Version

Peer reviewed version

[Link to publication record in King's Research Portal](#)

Citation for published version (APA):

Stubbs, B., Vancampfort, D., Veronese, N., Schofield, P., Lin, P-Y., Tseng, P-T., Solmi, M., Thompson, T., Carvalho, A. F., & Koyanagi, A. (2018). Multimorbidity and perceived stress: A population-based cross-sectional study among older adults across six low- and middle-income countries. *Maturitas*, 107, 84-91. <https://doi.org/10.1016/j.maturitas.2017.10.007>

Citing this paper

Please note that where the full-text provided on King's Research Portal is the Author Accepted Manuscript or Post-Print version this may differ from the final Published version. If citing, it is advised that you check and use the publisher's definitive version for pagination, volume/issue, and date of publication details. And where the final published version is provided on the Research Portal, if citing you are again advised to check the publisher's website for any subsequent corrections.

General rights

Copyright and moral rights for the publications made accessible in the Research Portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognize and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the Research Portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the Research Portal

Take down policy

If you believe that this document breaches copyright please contact librarypure@kcl.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.

Accepted Manuscript

Title: Multimorbidity and perceived stress: A population-based cross-sectional study among older adults across six low- and middle-income countries

Authors: Brendon Stubbs, Davy Vancampfort, Nicola Veronese, Patricia Schofield, Pao-Yen Lin, Ping-Tao Tseng, Marco Solmi, Trevor Thompson, André F. Carvalho, Ai Koyanagi



PII: S0378-5122(17)30775-2
DOI: <https://doi.org/10.1016/j.maturitas.2017.10.007>
Reference: MAT 6901

To appear in: *Maturitas*

Received date: 20-7-2017
Revised date: 21-9-2017
Accepted date: 9-10-2017

Please cite this article as: Stubbs Brendon, Vancampfort Davy, Veronese Nicola, Schofield Patricia, Lin Pao-Yen, Tseng Ping-Tao, Solmi Marco, Thompson Trevor, Carvalho André F, Koyanagi Ai. Multimorbidity and perceived stress: A population-based cross-sectional study among older adults across six low- and middle-income countries. *Maturitas* <https://doi.org/10.1016/j.maturitas.2017.10.007>

This is a PDF file of an unedited manuscript that has been accepted for publication. As a service to our customers we are providing this early version of the manuscript. The manuscript will undergo copyediting, typesetting, and review of the resulting proof before it is published in its final form. Please note that during the production process errors may be discovered which could affect the content, and all legal disclaimers that apply to the journal pertain.

Multimorbidity and perceived stress: a population-based cross-sectional study among older adults across six low- and middle-income countries

Running title: stress and multimorbidity

Brendon Stubbs PhD^{1-3*^}, Davy Vancampfort PhD^{4-5^}, Nicola Veronese MD⁶, Patricia Schofield³, Pao-Yen Lin MD⁷⁻⁸, Ping-Tao Tseng MD⁹, Marco Solmi MD, PhD¹⁰, Trevor Thompson PhD¹¹, André F. Carvalho MD^{4, 12} Ai Koyanagi MD¹³⁻¹⁴

^ = Joint first authors

1. Physiotherapy Department, South London and Maudsley NHS Foundation Trust, Denmark Hill, London SE5 8AZ, United Kingdom
2. Health Service and Population Research Department, Institute of Psychiatry, Psychology and Neuroscience, King's College London, De Crespigny Park, London, Box SE5 8AF, United Kingdom
3. Faculty of Health, Social Care and Education, Anglia Ruskin University, Bishop Hall Lane, Chelmsford CM1 1SQ, United Kingdom
4. KU Leuven Department of Rehabilitation Sciences, Leuven, Belgium
5. KU Leuven, University Psychiatric Center KU Leuven, Leuven-Kortenberg, Belgium
6. National Research Council, Neuroscience Institute, Aging Branch, Padova, Italy
7. Department of Psychiatry, Kaohsiung Chang Gung Memorial Hospital and Chang Gung University College of Medicine, Kaohsiung, Taiwan
8. Institute for Translational Research in Biomedical Sciences, Kaohsiung Chang Gung Memorial Hospital, Kaohsiung, Taiwan
9. Department of Psychiatry, Tsyr-Huey Mental Hospital, Kaohsiung Jen-Ai's Home, Taiwan
10. Department of Neurosciences, University of Padova, Padova, Italy
11. Faculty of Education and Health, University of Greenwich, London, United Kingdom
12. Department of Clinical Medicine and Translational Psychiatry Research Group, Faculty of Medicine, Federal University of Ceará, Fortaleza, CE, Brazil
13. Research and Development Unit, Parc Sanitari Sant Joan de Déu, Universitat de Barcelona, Fundació Sant Joan de Déu, Sant Boi de Llobregat, Barcelona, Spain
14. Instituto de Salud Carlos III, Centro de Investigación Biomédica en Red de Salud Mental, CIBERSAM, Madrid, Spain

* **Corresponding Author:** Brendon Stubbs PhD, Head, Physiotherapy Department, South London and Maudsley NHS Foundation Trust, Denmark Hill, London, United Kingdom. Tel: 0044 208 3003100, fax 00442032282702 email: brendon.stubbs@kcl.ac.uk

Highlights

- We report the first multinational study specifically focusing on perceived stress and multimorbidity in older adults.
- We noted a linear increase in levels of perceived stress with increasing numbers of chronic conditions.
- For single chronic conditions, notably high scores for perceived stress were observed for depression, stroke, and hearing problems.

Abstract

Background

Stress in chronic conditions or multimorbidity (≥ 2 chronic conditions) has been reported to affect clinical outcomes but there are no studies on the association between stress and chronic conditions/multimorbidity among older adults in low- and middle-income countries (LMICs). Thus, we investigated this association among adults aged ≥ 50 years across six LMICs.

Methods

A cross-sectional analysis using data from the World Health Organization's Study on Global Ageing and Adult Health (China, Ghana, India, Mexico, Russia, South Africa) was conducted. A perceived stress score [range 0 (lowest stress) -100 (highest stress)] was computed based on two questions from the Perceived Stress Scale. Thirteen chronic conditions were assessed. Multivariable linear regression analyses were conducted.

Results

34,129 adults with a mean age of 62.4 (SD=16.0) years (52.1% females) were included. Overall, 56.6% (95% CI=55.0%-58.2%) had multimorbidity. In the adjusted model including all countries, compared with those with no chronic conditions, higher numbers of chronic conditions were significantly associated with higher stress levels, dose dependently. In a countrywide meta-analysis, multimorbidity was associated with significantly higher stress levels in all countries (especially India and Ghana) although characterized by moderate heterogeneity ($I^2=54.6\%$). For single chronic conditions, notably high stress scores were observed for depression, stroke, and hearing problems.

Conclusion

Chronic conditions and multimorbidity are associated with higher levels of stress in older adults in LMICs. Given that perceived stress and chronic conditions are collectively associated with worse health outcomes, low-cost, population-level integrated interventions to address stress among those with chronic conditions are urgently needed.

Keywords: multimorbidity, stress, older adults, chronic diseases, low- and middle-income countries, psychiatry

Introduction

The recent Lancet Global burden of disease series confirm that whilst the average life expectancy continues to increase, the numbers of years lived with disability are also increasing ^{1,2}. Of particular concern are the rising number of chronic conditions, such as chronic low back pain, arthritis, diabetes and chronic respiratory conditions which are associated with considerable disability-adjusted life years and healthcare utilization ³⁻⁵. With population ageing, people are now more likely to have multiple chronic conditions simultaneously, a condition often referred to as multimorbidity ⁶. Indeed, recent studies have suggested that between 13 and 72% of the general population has multimorbidity ^{7,8}, thus posing one of the greatest challenges in healthcare to our ageing population ^{6,9}. Multimorbidity is an important risk concept given its associated high healthcare costs, decreased quality of life and ultimately increased mortality ^{10,11}.

To date, most of the research investigating multimorbidity has been limited to a single country and a paucity of data exists from low- and middle-income countries (LMICs). Clearly, this limits the representativeness of the research, and a lack of research considering multimorbidity in LMICs is a concern, given the fact that an increasing proportion of the world's population resides in this setting and the average age continues to rise in this region ¹². Moreover, there is increasing recognition that there is a rising burden of the number of chronic conditions in LMICs, yet the healthcare systems are not well equipped to deal with this public health demand ¹³.

Research has also started to consider the mental or emotional health burden of multimorbidity, such as perceived stress ¹⁴, a state in which one perceives their life situations stressful ¹⁵. The relationship between some single chronic conditions and perceived stress has

been investigated to date, partly driven by the potential deleterious influence of stress on the patient's treatment outcomes and wellbeing. For instance, in patients with asthma, arthritis, chronic back pain or diabetes, stress may intensify the effect of illness by increasing pain, functional limitations, and disability, as well as decreasing adherence to medical treatment protocols,¹⁶⁻¹⁸ all of which may further exacerbate stress¹⁹.

Surprisingly, a paucity of multinational research has considered the relationship between multimorbidity and perceived stress. This is an important research gap given that a previous national Danish study identified that perceived stress may contribute to the heightened mortality in those with multimorbidity.¹¹ Previous research has suggested that multimorbidity is high in LMICs^{14,20} and perceived stress levels are high due to considerable economic, environmental and health uncertainties, including less access to physical health care. Thus, this adds to the pressing need to explore this relationship within this context in older adults. One recent study reported the association between chronic conditions, multimorbidity and perceived stress in LMICs using data from the World Health Survey¹⁴. Whilst novel, the data were older and the study was not restricted to older adults, who are the population typically with the highest levels of chronic conditions and multimorbidity. Furthermore, data from China, India, and Russia, which collectively comprise a large proportion of the global population were not nationally representative. In addition, individual country estimates were not provided despite the potential between-country differences in factors (e.g., underlying disease profile, availability of health insurance and optimal treatment) that may influence stress levels associated with chronic conditions or multimorbidity. Finally, due to a lack of data, important chronic conditions such as hypertension, stroke, and chronic obstructive pulmonary disease (COPD), which are major contributors to the global disease burden,²¹ could not be included in the previous analysis.

Given the aforementioned gaps in the literature, the aim of the current study was to assess whether a variety of chronic conditions and multimorbidity are associated with higher perceived stress levels among community-dwelling older adults using nationally representative data from six LMICs (China, Ghana, India, Mexico, Russia, South Africa) which broadly represent different geographical locations and levels of socio-economic and demographic transition.

Methods

The survey

Data from the Study on Global Ageing and Adult Health (SAGE) survey was analyzed. This dataset is publically available through the World Health Organization (WHO) website (<http://www.who.int/healthinfo/sage/en/>). The survey was undertaken in China, Ghana, India, Mexico, Russia, and South Africa between 2007 and 2010. Based on the World Bank classification at the time of the survey, Ghana was the only low-income country, and China and India were lower middle-income countries although China became an upper middle-income country in 2010. The remaining countries were upper middle-income countries.

Details of the survey methodology have been published elsewhere²². In brief, in order to obtain nationally representative samples, a multistage clustered sampling design method was used. The sample consisted of adults aged ≥ 18 years with oversampling of those aged ≥ 50 years. Following a common research protocol across countries, trained interviewers conducted face-to-face interviews using a standard questionnaire to collect information. The questionnaires were translated from English into the local languages, following the WHO translation guidelines. All interviews in Mexico were completed using a computer-assisted personal interview (CAPI), while a paper and pencil interview (PAPI) was used in the remaining countries with the exception of China where both CAPI and PAPI were used. The

interviewers also conducted measurements of weight, height, and blood pressure. A stadiometer and a routinely calibrated electronic weighting scale were used to measure height and weight respectively. Blood pressure was measured three times with a one-minute interval using a Boso Medistar Wrist Blood Pressure Monitor Model S.

If a respondent was unable to undertake the interview because of limited cognitive function, then a separate questionnaire was administered to a proxy respondent. These individuals were not included in the current study. The survey response rate ranged from 51% (Mexico) to 93% (China). Sampling weights were constructed to adjust for the population structure as reported by the United Nations Statistical Division. Ethical approval was obtained from the WHO Ethical Review Committee and local ethics research review boards. Written informed consent was obtained from all participants.

Perceived stress (Outcome)

In line with previous publications^{14,23,24}, we assessed perceived stress in the last month with the use of two questions which were taken from the Perceived Stress Scale²⁵. This validated scale has been widely used to measure perceived stress worldwide. The questions asked were: “How often have you felt that you were unable to control the important things in your life?”; and “How often have you found that you could not cope with all the things that you had to do?” The answer options to these questions were: never (score=1), almost never (score=2), sometimes (score=3), fairly often (score=4), very often (score=5). As in a previous study which used the identical questions to measure perceived stress¹⁴, we conducted factor analysis with polychoric correlations to incorporate the covariance structure of the answers provided for individual questions measuring a similar construct. The principal component method was used for factor extraction, while factor scores were obtained using the regression

scoring method. These factor scores were later converted to scores ranging from 0-100 with higher values indicating higher levels of perceived stress ¹⁴.

Chronic conditions and multimorbidity (Exposures)

We included all 13 chronic conditions (angina, arthritis, asthma, cataract, chronic back pain, COPD, depression, diabetes, edentulism, hearing problems, hypertension, obesity, stroke) for which data was available in the SAGE. These conditions have been included in previous studies on multimorbidity ^{14,26}. Chronic back pain was defined as having had back pain everyday during the last 30 days. Respondents who answered affirmatively to the question “Have you lost all of your natural teeth?” were considered to have edentulism. The participant was considered to have hearing problems if the interviewer observed this condition during the survey. Hypertension was defined as having at least one of the following: systolic blood pressure ≥ 140 mmHg; diastolic blood pressure ≥ 90 mmHg; or self-reported diagnosis. We used the mean of the available measurements for blood pressure. Obesity was defined as BMI ≥ 30 kg/m² based on measured weight and height. Diabetes and stroke were solely based on lifetime self-reported diagnosis (Actual question can be found in Web Appendix **eTable 1**).

For other conditions, the participant was considered to have the condition in the presence of either one of the following: self-reported diagnosis (**eTable 1**); or symptom-based diagnosis based on algorithms (Details on the algorithms are available in Web Appendix **eTable 2**). We used these algorithms, which have been used in previous studies using the same dataset, to detect undiagnosed cases ^{26,27}. Specifically, the validated Rose questionnaire was used for angina ²⁸, and other previously validated symptom-based algorithms were used for arthritis, asthma, and COPD ^{27,29}. Questions based on the World Mental Health Survey version of the Composite International Diagnostic Interview ³⁰ were

used for the endorsement of DSM-IV depression ³¹. The total number of chronic conditions was calculated and categorized as 0, 1, 2, 3, and ≥ 4 . Multimorbidity was defined as ≥ 2 chronic conditions, in line with previously used definitions ²⁶.

Control variables

These included age (50-59, 60-69, 70-79, ≥ 80 years), sex, education, and wealth. Education was based on the highest level of education completed and was categorized as primary or less, secondary, and tertiary or higher. Wealth quintiles were created based on country-specific income.

Statistical analysis

The statistical analysis was performed with Stata 14.1 (Stata Corp LP, College station, Texas). The analysis was restricted to those aged ≥ 50 years given the focus of this study on older individuals. We conducted multivariable linear regression analysis to assess the association between the number of chronic conditions including multimorbidity (≥ 2 chronic conditions) or each of the 13 chronic conditions (exposure variables) and perceived stress score (outcome) using the overall and country-wise samples. All models were adjusted for sex, age, education, and wealth ¹⁴. The model using the overall sample was additionally adjusted for country by including dummy variables for each country ³². For the analyses on the individual chronic conditions, we also adjusted for the presence of other illnesses in order to address confounding by comorbid chronic conditions ¹⁴. The variable on other illnesses included information on whether the individual had any other chronic conditions apart from the chronic condition in question (Y/N).

In order to assess the between-country heterogeneity that may exist in the association between multimorbidity and perceived stress, we calculated the Higgins' I^2 based on

estimates for each country. The Higgins' I^2 represents the degree of heterogeneity that is not explained by sampling error with a value of <40% often considered as negligible and 40-60% as moderate heterogeneity³³. A pooled estimate was obtained by random-effect meta-analysis.

All variables were included in the models as categorical variables with the exception of the perceived stress score (continuous variable). Under 5% of the data were missing for all the variables used in the analysis with the exception of number of chronic diseases (7.4%). No attempts to impute missing data were made, as we did not have information about whether these data are missing at random³⁴. Thus, complete-case analysis was done. The sample weighting and the complex study design were taken into account in all analyses with the use of the Taylor linearization method. Results from the linear regression models are presented as unstandardized b-coefficients with 95% confidence intervals (CIs). The level of statistical significance was set at $p < 0.05$.

Results

After restricting to those aged ≥ 50 years, the sample size was 34,129 (China 13,175; Ghana 4,305; India 6,560; Mexico 2,313; Russia 3,938; South Africa 3,838). The overall mean (SD) age was 62.4 (16.0) years and 52.1% were females (**Table 1**). The mean age was similar across countries but the proportion of females was high in Russia (61.1%). The prevalence of individual chronic conditions ranged widely between countries [e.g., depression 1.3% (China) to 16.9% (Mexico); Obesity 2.8% (India) to 47.1% (South Africa)].

The overall prevalence of multimorbidity was 56.6% (95%CI=55.0%-58.2%) and ranged from 46.0% (China) to 71.0% (Russia). A linear increase in the levels of perceived stress with increasing numbers of chronic conditions was observed in all the samples with the exception of that of Mexico and South Africa (**Figure 1**). In the overall adjusted model, compared to those with no chronic conditions, higher numbers of chronic conditions were significantly associated with higher stress levels in a dose-dependent fashion (**Table 1**). Similar trends were observed for China, Ghana, and India. In Mexico and South Africa, only the highest number of chronic conditions was significantly associated with higher mean stress scores, while no significant associations were observed in Russia.

The country-wise adjusted estimates of the associations between multimorbidity and perceived stress are illustrated in **Figure 2**. Multimorbidity was associated with significantly higher stress levels in all countries (especially India and Ghana) with the exception of Russia and Mexico, with a moderate level of heterogeneity being observed ($I^2=54.6\%$). In terms of the individual chronic conditions, after adjustment, in the overall sample, all conditions were significantly associated with higher stress levels with the exception of edentulism, hypertension, and obesity (**Table 3**). Particularly high mean stress scores were observed for

depression, stroke, and hearing problems. Depression was the only condition significantly associated with higher stress levels across all countries, while hypertension and obesity were not significantly associated with stress in any of the countries. For other conditions, there was a wide variation in the magnitude of the associations.

Discussion

To the best of our knowledge, the current paper is the first multi-national study specifically in older adults that has investigated the relationship between perceived stress and chronic conditions and multimorbidity. Overall, in our sample of individuals aged ≥ 50 years from six LMICs, we identified that over a half had multimorbidity, and greater numbers of chronic conditions were associated with higher levels of stress in a dose-dependent fashion. Moreover, we identified that notably high perceived stress was evident for depression, stroke, and hearing problems in the overall sample with the association between depression being consistent across all countries. However, hypertension and obesity were not significantly associated with stress in any of the countries. For most conditions, interestingly, we noted some geographical variations in the relationship with perceived stress. The countrywide meta-analysis indicated a moderate level of between-country heterogeneity in the relationship between perceived stress and multimorbidity. Our results are broadly similar to a previous publication¹⁴ considering perceived stress and multimorbidity across all ages in LMICs, which also found evidence of a dose response relationship between an increasing number of chronic conditions and higher perceived stress. Regarding individual chronic conditions, both studies found a strong relationship between perceived stress and depression and asthma.

In terms of the individual chronic conditions, the finding that depression was the only consistent chronic condition that was associated with perceived stress in all countries may not be surprising. Depression is known to negatively impact an individual's ability to cope with life, and stress may actually precede the onset of an episode of depression⁴². Alternatively, lack of social support may underlie both depression and perceived stress⁴³. Moreover, depression is known to be associated with a range of changes in inflammation^{44 45} which may potentially account for this observed relationship. One should also consider that the

strong relationship between depression and stress may in part be accounted for by some overlap in core symptoms⁴⁶. Finally, depression itself is associated with increased cardiovascular disease⁴⁷, which in turn is *per se* associated with higher perceived stress. .

For all chronic conditions, it is also possible that the symptoms of the diseases *per se* or the associated disability increase stress levels by restricting an individual's ability to engage in daily activities etc. Alternatively, for some diseases such as stroke and cardiovascular disease, previous studies have shown that perceived stress may lead to the future occurrence of these conditions⁴⁸. It may also be that the high treatment costs associated with some of these conditions lead to high levels of stress, although no study has investigated such an association. The reasons for the between-country differences in the association between some physical conditions and stress are unknown, but it may partly be explained by differences in insurance coverage, availability of treatment, and years lived with disability. For example, in some countries such as India, out-of-pocket payment and catastrophic expenditure for health care is common, and it is possible that having a chronic condition is particularly stressful in this setting due to the economic consequences⁴⁹. In addition, in some countries where there may be high treatments costs, it is conceivable that patients forgo needed treatment, in particular when there is a need for multiple medications, which are often prescribed to treat chronic diseases and multimorbidity. Untreated chronic conditions may increase the severity of the chronic condition or lead to further complications, which may increase levels of perceived stress. Next, it is also possible that treatment options are limited especially in resource-limited settings and that the same condition may not result in the same level of disability and stress in all settings. For example, in the case of edentulism, dentures and dental implants, which are known to substantially improve the negative consequences of edentulism, may be prohibitively expensive or unavailable in some settings. It is also worthy

of noting that we found no evidence in any country of a relationship between perceived stress and hypertension or obesity. This may be of no surprise given that of all the chronic conditions assessed, these are the only two which may potentially be asymptomatic. Nonetheless, a previous small (n=101) study among low income females in the United States found that perceived stress was associated with excessive eating behaviors and poor diet ⁵⁰. However, the availability of poor quality and excessive food, commonly associated with obesity in western cultures, may not be so widely available and used as a coping mechanism in LMICs.

The current study is cross sectional and no causal inferences can be ascertained from our data and an important first step is to conduct prospective research to disentangle the relationship between multimorbidity and stress. However, several hypotheses can be suggested regarding the underlying mechanisms of this association. First, chronic stress is known to lead to neuroendocrine dysregulation of the hypothalamic-pituitary-adrenal axis, which in turn may cause changes in the immune and inflammation system, and consequently lead to the development of chronic conditions and multimorbidity ³⁵, commonly conceptualized as allostatic load ^{36,37}. Even subclinical perceived stress has been linked to changes in cortisol levels, the immune system response, and cortical reactivity ³⁸. Such processes may underpin the relationship between stress and chronic conditions such as stroke. Finally, perceived stress may also lead to unhealthy behaviors, such as smoking, excess alcohol consumption, unhealthy dietary choices ^{39,40} and a physical inactivity ⁴¹, which might also be implicated in the development of chronic conditions and multimorbidity and the associated perceived stress may lead to an increased inflammatory response. Alternatively, chronic conditions and multimorbidity may lead to difficulties undertaking ADL and social restriction which may increase perceived stress. Clearly future longitudinal research is therefore required to better

understand the directionality of the relationships we observed and specifically the impact of lifestyle on the stress and chronic condition trajectory.

Multimorbidity was associated with higher levels of stress in all countries although this relationship was not significant in Russia and Mexico. The meta-analysis showed a moderate level of heterogeneity between countries. This between-country difference may be related with the factors mentioned above such as the availability of health insurance and differing levels of disability associated with the conditions between countries⁴⁹. Apart from these factors, in the case of multimorbidity, it is also likely that the combination of the diseases differed and that that led to a difference in its magnitude of association with stress. A previous study using the same dataset showed that there are distinct patterns of multimorbidity in different countries and that, for instance, a mental-articular pattern is common in China, Ghana and India ²⁶. Furthermore, based on our finding that there was a large between-country variation in the prevalence of hypertension and obesity, which are conditions unrelated with stress in the current study, we also hypothesized that the association between multimorbidity and stress may have been attenuated especially in countries such as Mexico, Russia, and South Africa where the prevalence of these conditions were particularly high ²⁶. In order to assess the extent to which the prevalence of obesity and hypertension influenced the between-country differences, we conducted a sensitivity analysis by excluding obesity and hypertension when counting the number of chronic conditions. The results indicate that the strength of the association increased in all countries, especially Mexico, although the association remained non-significant in Russia (Appendix **eFigure 1**).

Clearly, our research adds to the growing calls for healthcare systems to adapt to the rising issue of multimorbidity and poor mental health. Moreover, perceived stress is associated with

increased mortality in those with multimorbidity in Western cultures ¹¹ and it is likely this combination adds to worse outcomes in LMICs also. Addressing this issue is a unique challenge in LMICs, where resources are often sparse and care may be fragmented. An important first step is raising awareness of the importance of considering chronic conditions and perceived stress among primary and mental health care providers in LMICs, and our research suggests that depression is in particular associated with perceived stress. Better communication with health professionals to identify those with multimorbidity and stress is essential. Future research should seek to identify people with chronic conditions and develop integrated care pathways. Low cost, population level interventions, such as developing a healthy lifestyle may play a pivotal role in the prevention and also management of chronic conditions and ultimately multimorbidity. Moreover, such interventions, including physical activity may also help alleviating stress levels ⁵¹. Given the cross-sectional nature of our work, prospective research should also attempt to disentangle the directionality of the relationships we observed.

Whilst our research is novel, a number of limitations should be noted. The primary limitation is that we cannot deduce the directionality of the associations we observed in our study. Second, whilst we included 13 chronic conditions in our study, clearly there may be additional chronic diseases that were not covered by the SAGE database that we did not identify. In particular, we did not have information on HIV, which is known to be particularly prevalent and deleterious for people in LMICs ⁵² and perceived stress ⁵³. In addition, we did not have information on important geriatric syndromes such as malnutrition or frailty. Thus, future research is required to investigate the relationship with these outcomes and perceived stress. Third, whilst the use of self-report medical diagnoses is valid in western settings, the validity and reliability in LMICs has not been fully established ²⁶. Nonetheless, despite the

aforementioned, our study is the first multi-national study to investigate the relationship between perceived stress and chronic conditions/multimorbidity in older adults. Furthermore, the study used nationally representative data from six countries which represent a large proportion of the world population, while it included a large number of chronic conditions.

Conclusion

Our study illustrates that older individuals with chronic conditions or multimorbidity are exposed to higher levels of stress in LMICs although some between-country differences exist. Given that previous research has demonstrated that perceived stress and chronic conditions are collectively associated with worse outcomes, our findings highlight the growing need to develop low cost, population-level integrated interventions to address stress among those with chronic conditions in this region.

Contributors

All authors contributed to the conception and design of the study, the data analysis and interpretation, and the writing of the paper. BS and DV are joint first authors.

Funding

Brendon Stubbs receives funding from the National Institute for Health Research Collaboration for Leadership in Applied Health Research & Care Funding scheme. The views expressed in this publication are those of the author(s) and not necessarily those of the NHS, the National Institute for Health Research or the Department of Health. Ai Koyanagi's work was supported by the Miguel Servet contract financed by the CP13/00150 and PI15/00862 projects, integrated into the National R + D + I and funded by the ISCIII - General Branch

Evaluation and Promotion of Health Research - and the European Regional Development Fund (ERDF-FEDER).

Ethical approval

This project is a secondary analysis of a publically available data set. Ethical approval was obtained from the WHO Ethical Review Committee and local ethics research review boards. Written informed consent was obtained from all participants.

Conflict of interest

The authors declare that they have no conflict of interest.

Provenance and peer review

This article has undergone peer review.

Research data (data sharing and collaboration)

There are no linked research data sets for this paper. Data will be made available on request.

References

1. Murray CJ, Barber RM, Foreman KJ, et al. Global, regional, and national disability-adjusted life years (DALYs) for 306 diseases and injuries and healthy life expectancy (HALE) for 188 countries, 1990-2013: quantifying the epidemiological transition. *Lancet*. 2015;386(10009):2145-2191.
2. Murray CJ, Vos T, Lozano R, et al. Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet*. 2013;380(9859):2197-2223.
3. To T, Stanojevic S, Moores G, et al. Global asthma prevalence in adults: findings from the cross-sectional world health survey. *BMC Public Health*. 2012;12:204.
4. Stewart Williams J, Ng N, Peltzer K, et al. Risk Factors and Disability Associated with Low Back Pain in Older Adults in Low- and Middle-Income Countries. Results from the WHO Study on Global AGEing and Adult Health (SAGE). *PLoS One*. 2015;10(6):e0127880.
5. Smith E, Hoy DG, Cross M, et al. The global burden of other musculoskeletal disorders: estimates from the Global Burden of Disease 2010 study. *Ann Rheum Dis*. 2014;73(8):1462-1469.
6. Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. *Lancet*. 2012;380(9836):37-43.
7. Fortin M, Stewart M, Poitras ME, Almirall J, Maddocks H. A systematic review of prevalence studies on multimorbidity: toward a more uniform methodology. *Ann Fam Med*. 2012;10(2):142-151.
8. Fortin M, Lapointe L, Hudon C, Vanasse A, Ntetu AL, Maltais D. Multimorbidity and quality of life in primary care: a systematic review. *Health Qual Life Outcomes*. 2004;2:51.
9. Lehnert T, Heider D, Leicht H, et al. Review: health care utilization and costs of elderly persons with multiple chronic conditions. *Med Care Res Rev*. 2011;68(4):387-420.
10. Ryan A, Wallace E, O'Hara P, Smith SM. Multimorbidity and functional decline in community-dwelling adults: a systematic review. *Health Qual Life Outcomes*. 2015;13:168.
11. Prior A, Fenger-Gron M, Larsen KK, et al. The Association Between Perceived Stress and Mortality Among People With Multimorbidity: A Prospective Population-Based Cohort Study. *Am J Epidemiol*. 2016.
12. World-Health-Organisation. Active Ageing Policy Framework. In. http://apps.who.int/iris/bitstream/10665/67215/1/WHO_NMH_NPH_02.8.pdf 20112.
13. Miranda JJ, Kinra S, Casas JP, Davey Smith G, Ebrahim S. Non-communicable diseases in low- and middle-income countries: context, determinants and health policy. *Trop Med Int Health*. 2008;13(10):1225-1234.
14. Vancampfort D, Koyanagi A, Ward P, et al. Perceived Stress and its Relationship with Chronic Conditions and Multimorbidity Among 229,293 Community-Dwelling Adults in 44 Low-and Middle-Income Countries. *American journal of epidemiology*. 2017.
15. CA P. Perceived stress. In: In: Encyclopedia of Behavioral Medicine. pp 1453-1454. Springer Science and Business Media, New York, 20132013.

16. Santiago T, Geenen R, Jacobs JW, Da Silva JA. Psychological factors associated with response to treatment in rheumatoid arthritis. *Curr Pharm Des.* 2015;21(2):257-269.
17. Aikens JE. Prospective associations between emotional distress and poor outcomes in type 2 diabetes. *Diabetes Care.* 2012;35(12):2472-2478.
18. Lavoie KL, Bouthillier D, Bacon SL, et al. Psychologic distress and maladaptive coping styles in patients with severe vs moderate asthma. *Chest.* 2010;137(6):1324-1331.
19. Tola HH, Shojaeizadeh D, Garmaroudi G, et al. Psychological distress and its effect on tuberculosis treatment outcomes in Ethiopia. *Glob Health Action.* 2015;8:29019.
20. Vancampfort D, Koyanagi A, Ward PB, et al. Chronic physical conditions, multimorbidity and physical activity across 46 low- and middle-income countries. *Int J Behav Nutr Phys Act.* 2017;14(1):6.
21. Vos T, Flaxman AD, Naghavi M, et al. Years lived with disability (YLDs) for 1160 sequelae of 289 diseases and injuries 1990–2010: A systematic analysis for the Global Burden of Disease Study 2010. *The Lancet.* 2012;380(9859):2163-2196.
22. Kowal P, Chatterji S, Naidoo N, et al. Data resource profile: the World Health Organization Study on global AGEing and adult health (SAGE). *International journal of epidemiology.* 2012;41(6):1639-1649.
23. Stubbs B, Koyanagi A, Thompson T, et al. The epidemiology of back pain and its relationship with depression, psychosis, anxiety, sleep disturbances, and stress sensitivity: Data from 43 low- and middle-income countries. *General hospital psychiatry.* 2016;43:63-70.
24. DeVlyder JE, Koyanagi A, Unick J, Oh H, Nam B, Stickley A. Stress Sensitivity and Psychotic Experiences in 39 Low- and Middle-Income Countries. *Schizophrenia bulletin.* 2016;42(6):1353-1362.
25. Cohen S, Kamarck T, Mermelstein R. A global measure of perceived stress. *Journal of health and social behavior.* 1983;24(4):385-396.
26. Garin N, Koyanagi A, Chatterji S, et al. Global Multimorbidity Patterns: A Cross-Sectional, Population-Based, Multi-Country Study. *The journals of gerontology Series A, Biological sciences and medical sciences.* 2016;71(2):205-214.
27. Arokiasamy P, Uttamacharya, Kowal P, et al. Chronic Noncommunicable Diseases in 6 Low- and Middle-Income Countries: Findings From Wave 1 of the World Health Organization's Study on Global Ageing and Adult Health (SAGE). *American journal of epidemiology.* 2017;185(6):414-428.
28. Rose GA. The diagnosis of ischaemic heart pain and intermittent claudication in field surveys. *Bull World Health Organ.* 1962;27:645-658.
29. Moussavi S, Chatterji S, Verdes E, Tandon A, Patel V, Ustun B. Depression, chronic diseases, and decrements in health: results from the World Health Surveys. *Lancet.* 2007;370(9590):851-858.
30. Kessler RC, Ustun TB. The World Mental Health (WMH) Survey Initiative Version of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI). *Int J Methods Psychiatr Res.* 2004;13(2):93-121.
31. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders (4th ed.).* 2000.
32. Koyanagi A, Garin N, Olaya B, et al. Chronic conditions and sleep problems among adults aged 50 years or over in nine countries: a multi-country study. *PloS one.* 2014;9(12):e114742.
33. Higgins JP, Thompson SG. Quantifying heterogeneity in a meta-analysis. *Stat Med.* 2002;21(11):1539-1558.
34. Little RJA, Rubin DB. *Statistical analysis with missing data.* New York: Wiley; 1987.

35. Goldstein DS, McEwen B. Allostasis, homeostats, and the nature of stress. *Stress*. 2002;5(1):55-58.
36. McEwen BS. Central effects of stress hormones in health and disease: Understanding the protective and damaging effects of stress and stress mediators. *Eur J Pharmacol*. 2008;583(2-3):174-185.
37. McEwen BS. Biomarkers for assessing population and individual health and disease related to stress and adaptation. *Metabolism*. 2015;64(3 Suppl 1):S2-s10.
38. Sladek MR, Doane LD, Luecken LJ, Eisenberg N. Perceived stress, coping, and cortisol reactivity in daily life: A study of adolescents during the first year of college. *Biol Psychol*. 2016;117:8-15.
39. Yoon SJ, Kim HJ, Doo M. Association between perceived stress, alcohol consumption levels and obesity in Koreans. *Asia Pac J Clin Nutr*. 2016;25(2):316-325.
40. Errisuriz VL, Pasch KE, Perry CL. Perceived stress and dietary choices: The moderating role of stress management. *Eat Behav*. 2016;22:211-216.
41. Stults-Kolehmainen MA, Sinha R. The effects of stress on physical activity and exercise. *Sports Med*. 2014;44(1):81-121.
42. Ghorbani N, Krauss SW, Watson PJ, Lebreton D. Relationship of perceived stress with depression: complete mediation by perceived control and anxiety in Iran and the United States. *Int J Psychol*. 2008;43(6):958-968.
43. Gao LL, Chan SW, Mao Q. Depression, perceived stress, and social support among first-time Chinese mothers and fathers in the postpartum period. *Res Nurs Health*. 2009;32(1):50-58.
44. Kohler CA, Freitas TH, Maes M, et al. Peripheral cytokine and chemokine alterations in depression: a meta-analysis of 82 studies. *Acta Psychiatr Scand*. 2017;135(5):373-387.
45. Black CN, Bot M, Scheffer PG, Cuijpers P, Penninx BW. Is depression associated with increased oxidative stress? A systematic review and meta-analysis. *Psychoneuroendocrinology*. 2015;51:164-175.
46. Lee E-H. Review of the psychometric evidence of the perceived stress scale. *Asian Nursing Research*. 2012;6(4):121-127.
47. Correll CU, Solmi M, Veronese N, et al. Prevalence, incidence and mortality from cardiovascular disease in patients with pooled and specific severe mental illness: a large-scale meta-analysis of 3,211,768 patients and 113,383,368 controls. *World Psychiatry*. 2017;16(2):163-180.
48. Booth J, Connelly L, Lawrence M, et al. Evidence of perceived psychosocial stress as a risk factor for stroke in adults: a meta-analysis. *BMC Neurol*. 2015;15:233.
49. Goepfel C, Frenz P, Grabenhenrich L, Keil T, Tinnemann P. Assessment of universal health coverage for adults aged 50 years or older with chronic illness in six middle-income countries. *Bull World Health Organ*. 2016;94(4):276-285c.
50. Richardson AS, Arsenault JE, Cates SC, Muth MK. Perceived stress, unhealthy eating behaviors, and severe obesity in low-income women. *Nutr J*. 2015;14:122.
51. Stubbs B, Vancampfort D, Rosenbaum S, et al. An examination of the anxiolytic effects of exercise for people with anxiety and stress-related disorders: A meta-analysis. *Psychiatry Res*. 2017;249:102-108.
52. Mdege ND, Shah S, Ayo-Yusuf OA, Hakim J, Siddiqi K. Tobacco use among people living with HIV: analysis of data from Demographic and Health Surveys from 28 low-income and middle-income countries. *Lancet Glob Health*. 2017;5(6):e578-e592.
53. Hand GA, Phillips KD, Dudgeon WD. Perceived stress in HIV-infected individuals: physiological and psychological correlates. *AIDS Care*. 2006;18(8):1011-1017.

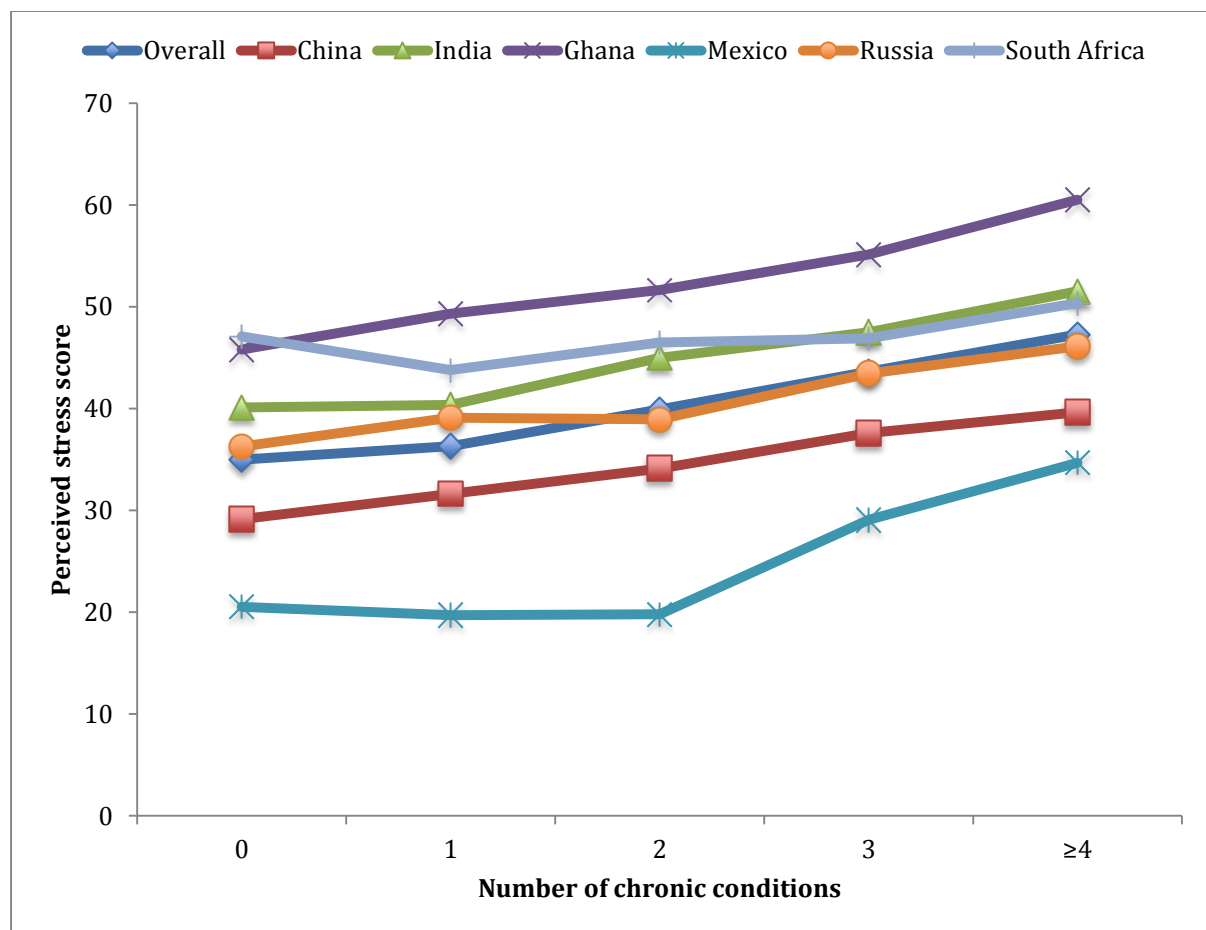


Figure 1 Mean perceived stress score by the number of chronic conditions and country
 The perceived stress score ranged from 0 to 100 with higher scores indicating higher levels of perceived stress.
 Estimates are based on weighted data.

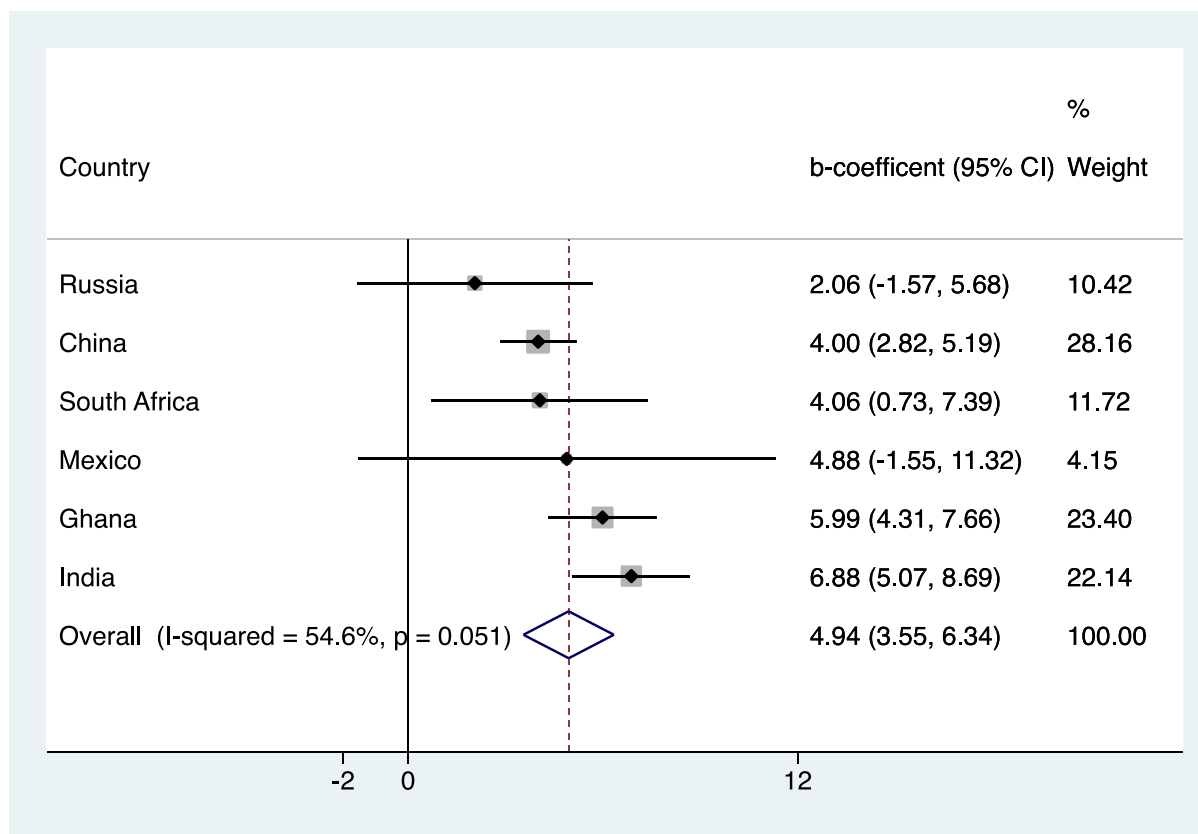


Figure 2 Country-wise associations between multimorbidity and perceived stress (outcome) estimated by multivariable linear regression

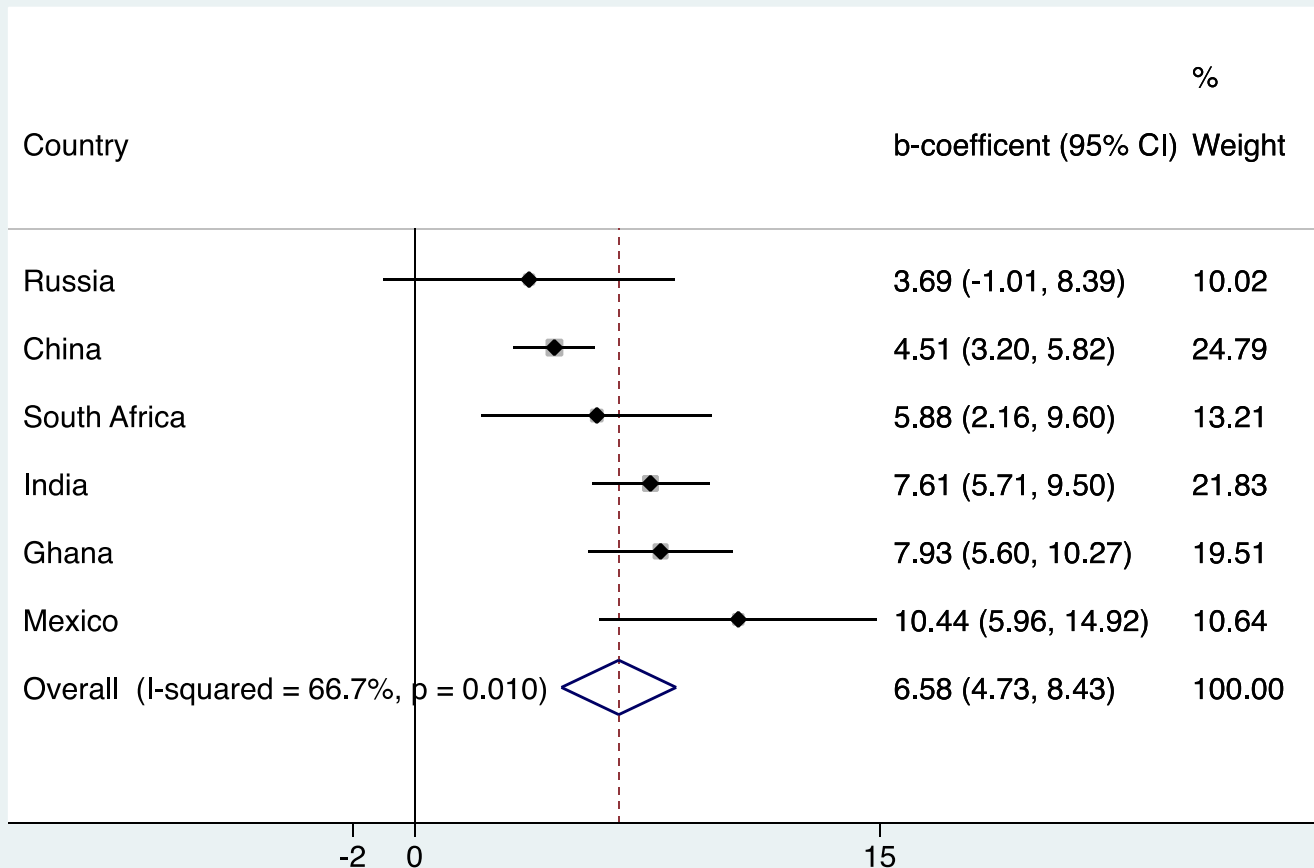
Abbreviation: CI Confidence Interval

Models were adjusted for age, sex, wealth, and education.

Multimorbidity was defined as ≥ 2 chronic conditions.

The perceived stress score ranged from 0 to 100 with higher scores indicating higher levels of perceived stress.

The overall estimate was obtained by random-effect meta-analysis.



eFigure 1 Country-wise associations between multimorbidity (without hypertension and obesity) and perceived stress (outcome) estimated by multivariable linear regression

Abbreviation: CI Confidence Interval

Models were adjusted for age, sex, wealth, and education.

Multimorbidity was defined as ≥ 2 chronic conditions.

The perceived stress score ranged from 0 to 100 with higher scores indicating higher levels of perceived stress.

The overall estimate was obtained by random-effect meta-analysis.

Table 1 Sample characteristics

Characteristic	Category	Overall	China	Ghana	India	Mexico	Russia	South Africa
Age (years)	50-59	46.4	44.9	39.7	48.6	48.1	45.2	49.9
	60-69	30.0	31.9	27.5	30.9	25.6	24.6	30.6
	70-79	18.2	18.6	23.1	16.0	17.8	21.8	14.0
	≥80	5.4	4.6	9.7	4.5	8.6	8.4	5.5
	Mean (SD)	62.4 (16.0)	62.6 (16.7)	64.4 (19.9)	61.5 (13.7)	63.0 (18.9)	63.9 (15.4)	61.6 (18.4)
Sex	Male	47.9	49.8	52.4	51.0	46.8	38.9	44.1
	Female	52.1	50.2	47.6	49.0	53.2	61.1	55.9
Education	≤Primary	57.4	63.0	75.3	76.1	79.6	7.5	71.4
	Secondary	35.2	32.5	21.1	18.8	12.3	74.2	22.8
	≥Tertiary	7.4	4.5	3.6	5.1	8.1	18.2	5.7
Wealth	Poorest	17.1	16.3	18.2	18.2	15.3	16.2	20.7
	Poorer	19.0	18.1	19.1	19.5	24.7	19.6	19.9
	Middle	19.5	20.5	20.5	18.8	16.8	19.1	18.2
	Richer	21.3	23.4	20.7	19.6	16.6	20.5	19.8
	Richest	23.1	21.8	21.6	23.9	26.6	24.6	21.3
Type of chronic condition	Angina	17.6	9.4	12.8	17.0	6.7	37.3	8.9
	Arthritis	29.5	26.7	26.2	27.9	14.5	38.2	30.6
	Asthma	7.9	4.3	5.0	12.5	4.9	6.5	7.7
	Cataract	27.3	14.2	18.1	47.4	25.8	20.3	6.4
	Chronic back pain	8.6	5.6	7.5	9.6	8.4	13.0	5.7
	COPD	15.8	11.3	3.7	17.2	13.2	24.4	7.4
	Depression	7.7	1.3	8.0	16.0	16.9	5.6	4.8
	Diabetes	6.8	6.6	3.8	6.9	17.6	7.0	9.2
	Edentulism	12.9	9.1	3.0	15.1	21.7	18.1	8.5
	Hearing problem	5.6	5.5	2.9	5.6	9.3	6.1	5.0
	Hypertension	55.0	60.6	59.6	37.5	61.9	72.1	78.3
	Obesity	11.6	6.0	10.5	2.8	28.5	32.0	47.1
	Stroke	3.0	3.0	2.8	2.0	4.3	4.8	4.0
Number of chronic conditions	0	16.4	19.1	18.0	16.6	7.6	12.6	6.8
	1	27.0	35.0	34.4	24.3	25.2	16.3	28.4
	2	22.6	23.5	26.6	22.3	27.9	19.6	31.3
	3	14.9	12.2	13.1	16.2	22.1	17.4	14.7
	≥4	19.2	10.2	7.9	20.6	17.2	34.0	18.9
Multimorbidity	≥2 Chronic conditions	56.6	46.0	47.6	59.1	67.2	71.0	64.9

Abbreviation: SD Standard Deviation. COPD Chronic Obstructive Pulmonary Disease

Data are weighted percentages unless otherwise stated.

Table 2 The association of number of chronic conditions and sociodemographic characteristics with perceived stress estimated by multivariable linear regression

Characteristic	Category	Overall	China	Ghana	India	Mexico	Russia	South Africa
Number of chronic conditions	0	Ref.	Ref.	Ref.	Ref.	Ref.	Ref.	Ref.
	1	1.05 [-0.27,2.37]	1.84** [0.59,3.08]	4.03*** [1.81,6.25]	0.39 [-2.43,3.21]	0.63 [-7.17,8.44]	1.59 [-1.79,4.96]	-1.19 [-6.96,4.59]
	2	3.30*** [1.78,4.82]	3.73*** [2.08,5.37]	6.65*** [4.32,8.97]	4.23** [1.40,7.06]	-0.25 [-7.16,6.67]	0.57 [-3.70,4.83]	1.03 [-4.93,6.99]
	3	6.03*** [4.35,7.71]	6.34*** [4.47,8.21]	9.44*** [6.34,12.54]	7.03*** [3.62,10.45]	8.37 [-0.31,17.05]	3.15 [-1.30,7.59]	3.16 [-2.97,9.30]
	≥4	8.59*** [6.09,11.09]	7.98*** [5.90,10.07]	14.69*** [11.24,18.13]	10.59*** [7.17,14.00]	13.58*** [5.93,21.23]	4.82 [-2.31,11.95]	6.78* [0.17,13.39]
Age (years)	50-59	Ref.	Ref.	Ref.	Ref.	Ref.	Ref.	Ref.
	60-69	0.54 [-0.65,1.72]	-0.55 [-1.78,0.68]	0.70 [-1.04,2.43]	0.45 [-1.38,2.27]	-0.77 [-6.43,4.89]	3.57 [-0.24,7.39]	2.57 [-0.94,6.09]
	70-79	1.92* [0.25,3.60]	1.06 [-0.68,2.80]	1.83 [-0.34,4.00]	0.42 [-2.18,3.01]	-2.22 [-8.97,4.52]	7.85*** [3.29,12.41]	1.20 [-3.96,6.36]
	≥80	4.87*** [2.58,7.17]	2.46 [-0.45,5.36]	7.06*** [3.37,10.75]	3.33 [-1.21,7.87]	-2.42 [-7.89,3.04]	12.36*** [7.44,17.28]	2.07 [-5.57,9.71]
Sex	Male	Ref.	Ref.	Ref.	Ref.	Ref.	Ref.	Ref.
	Female	1.26* [0.03,2.50]	2.92*** [1.91,3.93]	0.49 [-1.17,2.15]	-1.01 [-3.19,1.17]	2.07 [-3.36,7.49]	3.58 [-0.01,7.16]	-1.11 [-4.34,2.12]
Education	≤Primary	Ref.	Ref.	Ref.	Ref.	Ref.	Ref.	Ref.
	Secondary	-1.78** [-3.12,-0.45]	-0.58 [-2.00,0.85]	-3.20** [-5.46,-0.93]	-1.21 [-3.82,1.40]	2.85 [-5.38,11.07]	-3.84* [-7.64,-0.03]	-2.15 [-6.47,2.18]
	≥Tertiary	-1.68 [-4.21,0.86]	0.20 [-2.95,3.34]	-6.35*** [-11.05,-1.64]	-3.94 [-8.36,0.48]	-0.52 [-12.87,11.82]	-2.99 [-8.27,2.29]	-3.04 [-9.50,3.43]
Wealth	Poorest	Ref.	Ref.	Ref.	Ref.	Ref.	Ref.	Ref.
	Poorer	-3.32*** [-5.22,-1.42]	-3.13*** [-4.61,-1.65]	-0.99 [-3.11,1.14]	-3.17* [-5.96,-0.38]	-6.96 [-14.28,0.36]	-3.52 [-10.48,3.44]	-4.39 [-9.41,0.64]
	Middle	-4.68*** [-6.39,-2.98]	-6.76*** [-8.75,-4.76]	-2.61* [-5.12,-0.10]	-5.70*** [-9.06,-2.33]	-0.11 [-8.82,8.60]	1.23 [-2.55,5.01]	-8.34** [-13.49,-3.19]
	Richer	-7.99*** [-9.70,-6.29]	-9.35*** [-11.10,-7.60]	-5.37*** [-7.96,-2.78]	-10.23*** [-13.21,-7.24]	-7.39* [-13.08,-1.69]	0.03 [-4.20,4.27]	-13.19*** [-18.84,-7.54]
	Richest	-12.49*** [-14.68,-10.30]	-13.56*** [-15.58,-11.54]	-7.22*** [-10.27,-4.17]	-16.34*** [-20.41,-12.27]	-4.83 [-10.98,1.31]	-1.98 [-7.06,3.10]	-16.57*** [-22.05,-11.09]

Abbreviation: Ref. Reference category

Data are b-coefficient [95% confidence intervals].

Models are mutually adjusted for all variables in the Table. The model including all countries (overall) was additionally adjusted for country. The perceived stress score ranged from 0 to 100 with higher scores indicating higher levels of perceived stress.

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

Table 3 The association between the individual chronic conditions and perceived stress estimated by multivariable linear regression

Chronic condition	Overall	China	Ghana	India	Mexico	Russia	South Africa
Angina	2.36* [0.36,4.36]	5.32*** [3.43,7.20]	1.91 [-0.25,4.07]	2.51* [0.12,4.91]	11.84** [4.38,19.31]	-0.91 [-4.98,3.17]	5.80 [-0.26,11.86]
Arthritis	1.97** [0.53,3.42]	1.60** [0.53,2.68]	4.48*** [2.50,6.46]	2.91** [1.13,4.68]	3.19 [-1.48,7.86]	-0.69 [-5.45,4.07]	7.16*** [4.12,10.19]
Asthma	5.65*** [3.87,7.44]	6.24*** [3.58,8.90]	2.68 [-0.57,5.92]	4.72*** [1.97,7.47]	7.68** [2.16,13.19]	4.72* [1.08,8.37]	11.02*** [5.64,16.40]
Cataract	3.01*** [1.61,4.41]	0.03 [-1.58,1.63]	5.73*** [3.47,7.99]	3.51** [1.19,5.82]	7.82** [1.91,13.73]	4.35** [1.79,6.91]	-0.23 [-6.26,5.80]
Chronic back pain	3.67** [1.47,5.88]	4.77*** [2.04,7.50]	8.49*** [4.18,12.80]	4.61** [1.14,8.08]	5.47 [-0.60,11.55]	1.38 [-2.46,5.21]	6.63 [-0.76,14.02]
COPD	4.68*** [3.44,5.92]	1.36 [-0.37,3.09]	6.32* [1.21,11.44]	6.06*** [3.93,8.20]	8.50** [2.43,14.56]	5.44*** [2.74,8.14]	6.28* [0.22,12.34]
Depression	9.31*** [6.10,12.52]	16.49*** [12.15,20.84]	9.60*** [6.84,12.35]	7.82*** [3.77,11.88]	13.65*** [6.85,20.46]	9.74*** [5.76,13.72]	18.91*** [11.84,25.97]
Diabetes	2.78** [0.78,4.77]	1.51 [-1.18,4.20]	3.38 [-0.17,6.93]	2.97 [-0.65,6.58]	4.21 [-1.42,9.84]	7.14** [2.04,12.23]	-3.70 [-8.72,1.32]
Edentulism	0.92 [-0.83,2.67]	3.13*** [1.34,4.92]	9.22*** [4.41,14.02]	0.98 [-1.58,3.53]	2.69 [-3.86,9.25]	-0.86 [-4.23,2.50]	-0.29 [-5.89,5.31]
Hearing problem	6.75*** [4.18,9.32]	5.33*** [3.10,7.57]	5.54* [0.76,10.32]	6.87* [1.41,12.33]	16.36*** [9.03,23.69]	10.48*** [4.67,16.28]	1.16 [-8.03,10.35]
Hypertension	0.29 [-0.60,1.19]	0.73 [-0.25,1.71]	1.39 [-0.13,2.91]	1.16 [-0.53,2.85]	-2.35 [-8.57,3.87]	-0.80 [-3.62,2.03]	-2.10 [-4.94,0.75]
Obesity	1.09 [-1.24,3.43]	0.30 [-1.53,2.13]	-0.11 [-2.78,2.55]	2.38 [-1.62,6.38]	-4.23 [-10.34,1.87]	1.30 [-3.04,5.65]	0.87 [-2.41,4.15]
Stroke	7.64*** [5.03,10.25]	11.68*** [8.01,15.35]	10.35*** [5.28,15.41]	5.30 [-1.40,12.00]	1.20 [-5.62,8.02]	4.54 [-0.35,9.43]	4.69 [-2.68,12.06]

Abbreviation: Ref. Reference category; COPD Chronic Obstructive Pulmonary Disease

Data are b-coefficient [95% confidence intervals].

Models are adjusted for sex, age, wealth, education, and other illnesses. The model including all countries (overall) was additionally adjusted for country. The perceived stress score ranged from 0 to 100 with higher scores indicating higher levels of perceived stress.

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

eTable 1 Questions used to assess self-reported diagnosis

Condition	Question
Angina	Have you ever been diagnosed with angina or angina pectoris (a heart disease)?
Arthritis	Have you ever been diagnosed with/told you have arthritis (a disease of the joints, or by other names rheumatism or osteoarthritis)?
Asthma	Have you ever been diagnosed with asthma (an allergic respiratory disease)?
Cataract	In the last 5 years, were you diagnosed with a cataract in one or both of your eyes (a cloudiness in the lens of the eye)?
COPD	Have you ever been diagnosed with chronic lung disease (emphysema, bronchitis, COPD)?
Depression	Have you ever been diagnosed with depression?
Diabetes	Have you ever been diagnosed with diabetes (high blood sugar)? (not including diabetes associated with a pregnancy)
Hypertension	Have you ever been diagnosed with high blood pressure (hypertension)?
Stroke	Have you ever been told by a health professional that you have had a stroke?

eTable 2 Questions and answer options used for symptoms-based diagnosis

Condition	Symptom-based algorithm
Angina	Rose questionnaire
Arthritis	Affirmative answers to all four of the following: 1. During the last 12 months, have you experienced pain, aching, stiffness or swelling in or around the joints (e.g., in arms, hands, legs or feet) which were not related to an injury and lasted for more than a month? 2. During the last 12 months, have you experienced stiffness in the joint in the morning after getting up from bed, or after a long rest of the joint without movement? 3. Did this stiffness last for less than 30 minutes? 4. Did this stiffness go away after exercise or movement in the joint?
Asthma	1. During the last 12 months, have you experienced attacks of wheezing or whistling breathing? (Yes) AND 2. “Yes” to at least one of the following (past 12 months): (a) Have you experienced an attack of wheezing that came on after you stopped exercising or some other physical activity? (b) Have you had a feeling of tightness in your chest? (c) Have you woken up with a feeling of tightness in your chest in the morning or any other time? (d) Have you had an attack of shortness of breath that came on without an obvious cause when you were not exercising or doing some physical activity?
Cataract	1. In the last 12 months, have you experienced cloudy or blurry vision? (Yes) AND 2. In the last 12 months, have you experienced vision problems with light, such as glare from bright lights, or halos around lights? (Yes)
COPD	1. During the last 12 months, have you experienced any shortness of breath at rest (while awake)? (Yes) OR 2. “Yes” to both of the following (past 12 months): (a) Have you experienced any coughing or wheezing for 10 minutes or more at a time? (b) Have you experienced any coughing up of sputum or phlegm on most days of the month for at least 3 months?
Depression	1. At least one of the two following symptoms in the last 12 months: (a) A period, lasting several days, of feeling sad, empty or depressed. (b) A period lasting several days with a loss of interest in most things the participant usually enjoys such as personal relationships, work or hobbies/recreation. AND 2. The period of sadness/loss of interest/low energy lasted for more than two weeks and was most of the day and nearly every day. AND 3. Five or more of the following symptoms: (a) Loss of appetite (b) Insomnia (problems falling asleep or waking up too early) (c) Decreased energy or tiredness all the time (d) Slowing down in moving around or restless/jittery. (e) Negative feelings/loss of confidence or frequent feelings of hopelessness. (f) Slowed thinking or difficulties concentrating (e.g., listening to others, working, watching TV, listening to the radio). (g) Thoughts of death, wishes of own death or suicide attempt. (h) Feelings of sadness, emptiness or depression lasting several days. (i) Anhedonia: loss of interest in things the participant usually enjoys.

